NEW ENTRANT HEALTH HISTORY FORM

STUDENT'S NAME: _____ GRADE _____

PHYSICIAN'S NAME: _____ DATE OF BIRTH _____

1. **HEALTH HISTORY** (Check if yes)

☐ DIABETES ☐ CARDIAC PROBLEMS

☐ ORTHOPEDIC PROBLEMS ☐ CHRONIC EAR PROBLEMS

☐ ASTHMA ☐ ALLERGIES

☐ EPILEPSY (Seizures) OTHER: _____

2. Has your child ever been hospitalized overnight?

☐ No ☐ Yes DATE: _____ REASON: _____

_____

3. Does your child take medication of any kind? ☐ No ☐ Yes

If yes, name of medication(s): _____

4. Has your child ever had a head injury? ☐ No ☐ Yes If yes, describe: _____

_____

Please indicate if child lost consciousness: _____
Was your child hospitalized for this? ☐ No ☐ Yes

5. Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity or from participating in any activities? If yes, please explain. Mention any recent surgery, illness, broken bones, injuries, allergies (other than drugs) or other physical condition:

6. Do you or your child have any other concerns that you would like the school to be aware of?

For your child's safety – this information will be shared with those responsible for them.

_____ _____

Parent/Guardian Signature or 6-digit Session Key from Online Pre-Registration Date